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Editorial Department.

Typhoid Fever in Children.

THERE is every reason to think that typhoid fever is not naturally, or necessarily, rarer among children than among older classes of the population. The fact that the disease is not often seen in infants and very young children is due rather to the absence of opportunities for infection than to any special immunity. Dr. Blackader, of Montreal, in his analysis of ten cases of enteric fever in childhood before the American Pediatric Society two years ago (Archives of Pediatrics), reported one case of the disease in a child one year, three under the age of two years and three under the age of three years. Altogether there were seventeen cases under the age of five years. Griffith gave similar figures in his paper of this year.

In the discussion of Dr. Blackader's paper Dr. Griffith said that in his experience typhoid fever is not infrequent under the age of two years, and that it is not rare even under one year of age, though it is difficult to recognize. He added that the position assumed by some pediatrists that continued fever in children must not be suspected of being typhoid fever unless it gives some clinically characteristic signs of that disease, while it is the custom to suspect all cases of continued fever in adults of being typhoid fever, unless it can be proved to be something else, is not only anomalous, and likely to lead to error, but it is altogether illogical. Dr. Rotch agreed with Dr. Griffith, and considered that while infants may not be susceptible as older children and adults, the difference in susceptibility is by no means sufficient to permit this being used as an element in diagnosis.

Professor Potain, of Paris, used to say that the diagnosis of typhoid fever in the adult was one of the most difficult of diagnostic problems, and in the child it constituted a veritable puzzle. There is no doubt that typhoid fever, especially in children under five years of age runs, not infrequently, a very anomalous clinical course, as is observed in what is regarded as a bronchial form of typhoid. The Widal test has done much to facilitate the recognition of typhoid fever in children and render diagnosis more assured, but even this has not proved as absolute as was at first antici-

pated. There is even in the adult a margin of at least 10 per cent of cases in which the Widal test is not definitely determinative. About 5 per cent of patients suffering from other febrile disorders give a positive Widal reaction, while at least 5 per cent fail to show evidence of the agglutinative property in the blood, notwithstanding that genuine typhoid fever is present.

In children the margin of possible error with the Widal test seems to be greater. Besides, the agglutinative reaction in them is prone to develop later in the disease than in adults. When we remember that such helpful symptoms as the presence of the characteristic spots, the occurrence of epistaxis, and the step-like temperature are often missed in children, we can readily understand that typhoid fever during early years may present an extremely difficult problem in diagnosis. According to Morse's statistics only a little over 60 per cent of the cases show spots, and these are apt to be fewer in number and more easily missed than in adults.

For a time it was considered that the diazo reaction in the urine which occurs more constantly in children, it is said, than in adults, would prove of valuable assistance in diagnosis. Later investigation with regard to this action shows, however, that the diazo test has probably very little pathognomonic significance in typhoid fever. It occurs in most infectious fevers, and it may occasionally be entirely absent in genuine typhoid; that is, running a characteristically clinical course. The absence of a leucocytosis in this disease is a diagnostic sign of value that should be considered.

It seems clear then that the diagnosis of typhoid fever in children must depend on the complete symptomatic picture presented together with the history of the possibilities of the infection, the main dependence being on the Widal test and leucocyte count.

For the treatment of typhoid fever in children, the Brand method in its original form is not always available. Children react too intensely to the full bath that is of such marked benefit to adults. As a rule, a sponging will replace the bath and prove effective in the reduction of the temperature. The temperature in children is more easily influenced by antipyretic measures, and there is never any need to produce shock by the use of water that is unnecessarily cold at the beginning of the treatment. As nervous symptoms are prone to become marked in children in consequence of the presence of febrile temperature, the ordinary tepid bath and drugs which are also soothing to the nervous system should be used.

It must be borne in mind that typhoid fever in children not only gives rise to nervous symptoms, but may actually invade the nervous system itself. Wentworth (Transactions of American Pediatric Society, 1899) collected from the literature some twenty cases in which it seemed clear that the typhoid bacillus was the active agent in the production of meningitis. In his own case, though the Widal test was negative typhoid bacilli in pure culture were found in the cerebrospinal fluid. The clinical picture in the case was almost exactly that of tuberculosis meningitis, and it seems advisable that especially during the existence of an epidemic of typhoid fever an absolute differential diagnosis of a meningitis should not

be made until a careful investigation of the microbic flora of the cerebro-spinal fluid has been instituted.

The nursing of children ill with typhoid is of even more importance than that of adults. The little patients are liable to be irresponsible, and may easily expose themselves to many dangers unless they are cared for with vigilance. Besides this, children are sure to be more uncleanly than adults, and the urine as well as the feces fairly swarm with the bacilli. Children and infants are apt to be handled much more than adults, so that if the nurse is not careful to exercise the most scrupulous cleanliness there is great danger for herself and others.

The prognosis of typhoid fever in children is not unfavorable. There is no doubt that a corresponding state of affairs obtains for the disease as for yellow fever. The two affections run so mild a course in children that they have proved the source from which infectious material has been distributed among older members of the population.

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Professor Adolf Lorenz.

An event of international interest was the coming of Professor Adolf Lorenz from Vienna to Chicago to treat a patient and to demonstrate his method of reduction of congenital dislocation of the hip. The event, largely by reason of the attention given to Prof. Lorenz by the popular press, has attracted wide-spread interest. In Chicago the medical profession heaped honors upon him, and the Northwestern University, with becoming scholastic dignity, conferred the degree of LL.D. upon him. After receiving these well-merited attentions, and giving freely of his knowledge and experience in the clinics of that great city, Prof. Lorenz made a tour to the Pacific Coast stopping en-route at Denver and other cities, where he again demonstrated his methods before the medical profession. On his return he visited St. Louis where he was received with great ovation by the profession and received rather overwhelming publicity from the public press. His demonstrations at the Polyclinic Hospital will long be remembered as a noteworthy event, first by reason of the personality of Lorenz, which is striking and pleasing, dignified and characterized by that simplicity and reserve which imparts confidence; second his skill and manual dexterity, showing him to be a great student of his specialty, original and resourceful. The operation which he performs—the so-called bloodless method—for reduction of congenital dislocation of the hip, was evolved after many discouragements with the open method of Hoffa. First, he modified the Hoffa operation by stretching and parting the muscles with much less cutting than by the Hoffa operation, and later, in 1892, conceived the idea of performing the operation entirely by manipulation. Since then he has gone on improving in his technic until now his operation is almost perfect. He has performed it more than a thousand times, and has demonstrated this operation in Berlin, St. Petersburg, Moscow, Constantinople, Cairo, Alexandria, Stockholm and other great cities of Europe, except in England. In this country he has given clinics freely, and before his return home he will have

demonstrated his operation in all of the leading medical centers His visit to this country will be one of lasting professional benefit and of gratitude to many patients whom he has seen. The surgeon will profit by his teachings, and the public receive the benefit of these teachings by the greater skill which surgeons will have in the treatment of congenital dislocations of the hip. Americans are a grateful people, and appreciate skill wherever it is shown—however, they too, are a credulous people, and will fall a prey to many incompetents who will by every means possible endeavor to make much out of the bloodless surgery idea. Self-styled specialists will revel in the opportunity presented to grow fat on the recent publicity given to "bloodless surgery." Inasmuch as the lay press has made much of the skill and personality of Lorenz, it should likewise be cautious in handling reports and advertisements of the imitators and "specialists" who will work "the graft" of bloodless surgery. All honor to Lorenz, who by his skill, his study and his personality, has given to the suffering ones this hope for relief from one of the most distressing afflictions of humanity. The one great lesson which physicians should learn from the Lorenz visit, and which he has endeavored to impart in all of his lectures, is that of early diagnosis and early treatment in order to give permanent relief from this affliction.

THE LORENZ OPERATION.

Doubtless our readers will be interested in a description of the Lorenz operation for dislocation of the hips. We, therefore, take the liberty of publishing an excellent detailed description which appeared in the *Illinois Medical Journal* for December by Dr. Edmund Andrews, M.D., LL.D., Professor Emeritus of Surgery in the Northwestern University, who observed the operation, and who is one of the foremost consulting surgeons of Chicago:

"As I observed his procedure closely, a condensed statement of the whole subject may be of interest.

"Congenital dislocations of the hip joints are somewhat rare. When they occur it is the opinion of obstetrical authorities that the displacement of this joint takes place some time before birth, and almost never as an accident of the delivery. It appears to be due to imperfect development of the acetabulum, the head of the femur, and of the capsular ligament. In other words, the undeveloped mechanism of the joint allows the head of the femur to be gradually drawn or pressed upward and backward *in utero*, and before labor commences.

"During the last ten years efforts have been made to treat these cases by two methods:

"1. By incisions down to the joint.—Through the open wound the operator clears out the acetabulum and when necessary enlarges and deepens it by curetting and gouging the bone. He then places the head of the femur in the enlarged cavity and closes the wound aseptically.

"Dr. Hoffa reported 248 open wound operations with ten deaths. About half the operations were perfectly successful. Of the other half ten died, as above stated, and the remainder had more or less imperfection of the function of the joint.

"2. The bloodless operation.—Prof. Lorenz, of Vienna, gave his attention earnestly to the development of this method. Five years ago he published a large number of cases, and since that many more. He seems to be a candid man. He admits failures, and lays no claim to infallibility. He says that from 50 to 70 per cent of the children obtain a perfect functional cure, so as to be able to run, jump, and use their limbs as well as anyone, but that anatomically the X-ray and other methods of examinations detect in these successful cases some harmless deviation from perfect form or structure. The remaining cases, amounting to about 40 per cent are usually greatly benefited, but still not functionally perfect.

"Mickulicz, of Breslau, in Germany, has also published a large number of cases of the bloodless operation, and claims a very high success.

"Lorenz's ideas and methods are as follows: The child should be allowed to reach an age above two years and not over five or six years before operating. In older children the operation becomes more difficult, and although some successes are obtained among them the ratio of failures is large. Prof. Lorenz brought with him from Vienna a highly trained assistant and several pieces of special apparatus to enable him to apply proper force to the limb and to hold the patient in desired positions.

"Anesthetics were given in full quantity. He remarked that it was of great importance to avoid haste in applying the necessarily great force, and insisted that one must proceed "*slowly—slowly*," so as to stretch and rupture the opposing muscles and ligaments very gradually, otherwise bones would be fractured. He says he has fractured the neck of the femur quite a number of times, but the shaft only once. His manipulations consist of flexions, rotations, tractions and finally very great forced abductions, so as to put the three abductor muscles on a violent stretch and make them rise up a firm, hard ridge under the skin near their origin at the pubis. Then, while an assistant maintains this powerful tension by forced abduction, he manipulates this muscular ridge pretty near the pubis by a chopping motion of the border of the hand and the pressure of the thumbs and of the closed fist until by great force and determined persistence he tears off the three great adductors from their origins at the pubis and ramus of the ischium. At the same time all the other tissues which resist extreme abduction are slowly stretched or torn until the femur is thoroughly loosened and the thigh can be swung freely out so as to stand out laterally at right angles to the axis of the body. This part of the operation gives an impression of terrific violence to one who sees it for the first time, and the necessity of judgment and skill in the operator is most manifest. The manipulations, rotations, and tractions are now patiently and adroitly continued until the head of the bone is felt and heard to snap into the acetabulum, or upon its rim, if the cavity is not large enough or empty enough to fully receive the head. If it is a double dislocation, both sides are treated in the same way, the bones are placed in position, with the two thighs standing out laterally at right angles to the body, for in no other position is it possible to keep the head of the femur down upon the acetabulum, because those cavities are in many cases very imperfectly developed.

"The next step is to wrap the thighs, as well as the pelvis, thickly with cotton compactly bandaged on. Some strips of soft porous cloth are laid next to the skin under the cotton, and extending above and below it, for purposes presently to be mentioned. Next plaster of Paris bandages are applied over the whole length of both thighs and across the back and front of the pelvis, so that the pelvis and both of the thighs are encased in one inflexible mass. The knees and legs are left free. The strips of soft cloth laid next to the skin and running beneath the plaster dressing are used to cleanse the skin from time to time by pulling them to and fro, and are renewed as often as needful by sewing clean strips to the ends of the soiled ones and then pulling them into position. The anus and urinary outlets are left uncovered.

"The plaster splint is kept on about six months, and some times longer, but the patient is allowed, after the first few days, to get out of bed and hobble about. When the splint is taken off the thighs are found, of course, to be standing out somewhat stiffly at right angles to the body. They must not be suddenly brought down, but by very slow and gradual manipulation from day to day, they are brought back to the line of the body. By this time the heads of the femur will be so well settled into the acetabula, either by adhesion or by repair of the capsular ligaments and synovial membranes, that they will remain there securely in most instances. In a few cases they will fail to preserve perfectly their correct position, but even then they are much nearer to it than before the operation, and much more useful for walking.

"It is perhaps too early as yet to determine with absolute certainty the relative value of the two methods, but my belief is that Lorenz's bloodless operation will be found the safest, and will, on the average, give the most useful limbs.

"American surgeons are favorably impressed with the personal qualities of Prof. Lorenz, both on account of his great skill in manipulation, and of his apparent honesty in admitting his failures when they occur.

"Operations somewhat similar to his have occasionally been done by Chicago surgeons, but it was a great pleasure to see the method demonstrated by the one most distinguished as its author and developer."

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Dr. G. Frank Lydston, of Chicago, has just returned from an extended tour of Australia, New Zealand, Samoa and the Hawaiian Islands.

Timothy Cole as a Reader.—Like most great men, Timothy Cole, known the last twenty years to America, the land of his youth and early manhood, only through his work, the work which keeps him in foreign galleries, is a wide and eager reader of the great world books, the Bible, Homer, Dante, Shakspere. "Emerson is one of the writers of whom no person should ever say, 'I have read him,' but always, 'I read him,'" said one wise teacher. And Emerson and Thoreau Timothy Cole reads constantly, his life and philosophy showing the influence of the intimate companionship.

The Reviewer's Table.

Books, Reprints, and Instruments for this department, should be sent to the Editors, St. Louis.

PRACTICAL MIDWIFERY. A Manual of Obstetrics for Students and Physicians, by Edward Reynolds, M.D., Assistant in Obstetrics, etc., and Franklin S. Newell, M.D., Assistant in Obstetrics and Gynecology in Harvard University Medical School, Boston. In one octavo volume of 531 pages, with 253 engravings, and 3 full-page colored plates. Philadelphia and New York: Lea Brothers & Co., Publishers, 1902. (Cloth, $3.75, net.)

This is truly a student's manual and a worthy one too, the details of practical obstetrics are clearly presented, and in such form that a student grasps the importance of every feature from gestation to convalescence. Treatment is modern. No obsolete methods are noted as the indications for treatment, especially surgical, are clearly set forth. The book is commendable throughout, the illustrations are good, and it should merit favorable reception from the students.

GENERAL PARESIS, PRACTICAL AND CLINICAL. By Robert Howland Chase, A.M., M. D., Physician-in-chief, Friends' Asylum for the Insane, Philadelphia; late Resident Physician, State Hospital, Norristown, Pennsylvania. 12mo. 290 pages. Illustrated. Philadelphia: P. Blakiston's Son & Co., 1012 Walnut St. (Cloth, $1.75.)

This is a valuable and timely book upon a subject that is growing in importance with the advance in civilization. Physicians in general practice especially need to be familiar with this disease in order that they may early recognize it and give it the consideration which it needs during its early stages. The disease is essentially chronic, but if there is a period when treatment is of avail it is during the prodromal period. Hence, the importance of early diagnosis. This book is exhaustive in its consideration of the subject, and presents the modern teachings as to etiology, pathology, etc. The author is one of the foremost alienists in this country—a man of wide experience, and one who views mental disease from the practical standpoint. F. P. N.

A TEXT-BOOK OF PHYSICAL DIAGNOSIS. For Students and Practitioners of Medicine. By Egbert LeFevre, M. D., Professor of Clinical Medicine and Associate Professor of Therapeutics, University and Bellevue Medical College, Attending Physician to Bellevue and St. Luke's Hospitals, etc., New York. 12mo., 440 pages, with 74 engravings and 12 plates. Philadelphia and New York: Lea Brothers & Co. Cloth, $2.25, net.)

A thorough understanding of physical diagnosis is the basis of success in internal medicine. The more precisely one can be founded on the principles of diagnosis, the more readily will he acquire that essentially personal acquisition, the practical ability to apply them. LeFevre has uniquely and concisely presented the whole scope of physical diagnosis,

bringing to his aids all of the latest approved methods, so that every chapter is fully, carefully and explicitly presented. We regard the feature of illustrations as deserving of great praise. They help to give precision to the physical facts as presented in the text. Physical diagnosis can only be learned by practice, but with such a book as a guide, the student has before him the practical facts, fully and completely presented. The special and most recent methods of diagnosis receive full consideration. Diseases of the respiratory tract, heart, blood vessels, abdominal organs, etc., are all carefully considered. We congratulate the author on his ability to say so much in a brief way; we also appreciate his practical application of physical facts in diagnosis. F. P. N.

PROGRESSIVE MEDICINE, Vol. II, June, and Vol. III, September, 1902. A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M.D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia. Octavo, handsomely bound in cloth, 40 pages, 28 illustrations. Philadelphia and New York: Lea Brothers & Co., Publishers. (Per volume, $2.50, by express prepaid to any address. Per annum, in four cloth-bound volumes, $10.00.)

The vast accumulation of medical literature has made it necessary that some means be established to classify, review and investigate the merits of the contributions being made, in order that what is valuable may be placed in shape for immediate reference. "Progressive Medicine" under the guidance of Dr. Hobart A. Hare is doing such work. How well this is done is evidenced by the carefully prepared contributions made by Dr. Hare's associates, which must be read to be appreciated.

The June number (Vol. II) contains contributions by Dr. Wm. B. Coley on the Surgery of the Abdomen, including Hernia—in which is reviewed in a thoroughly practical manner the latest and best of the literature of the year. Dr. John G. Clark reviews Gynecology in his usual clear and concise manner. The article on the Diseases of the Blood and Ductless Glands. Hemorrhagic and Metabolic Diseases is one of the most interesting contributions of the year, because it presents what is new in this field of inquiry which in recent years has attracted the attention of internalists, and pathologists. Every physician should by all means read this article as it places this intricate subject in attractive and practical form, so that it becomes of value to the physician in his study of disease. Dr. Edward Jackson reviews Ophthalmology with the skill and precision of the experienced and progressive student that he is. He always carefully sifts the best for his readers. The commentaries of the various editors are valuable aids to every one interested in the literature of medicine.

The September volume contains Diseases of the Thorax and its Viscera, including the Heart, Lungs and Blood Vessels by William Ewart, M.D,. F.R.C.P.; Dermatology and Syphilis by W. S. Gotthiel, M.D.; Diseases of the Nervous System by Wm. G. Spiller, M.D.; Obstetrics by Richard C. Norris, M.D. We believe every physician should have at hand this valuable series of books as a ready and latest commentary on the literature of medicine.

Original Department.

PAPERS for the Original Department should be in hand one month in advance, and contributed to THE MEDICAL FORTNIGHTLY exclusively. A liberal number of extra copies will be furnished authors, and reprints may be obtained at reasonable rates, if request accompanies the manuscript. Engravings from photographs furnished free.

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Plastic Surgery in Ophthalmology.

By Flavel B. Tiffany, M. D.

KANSAS CITY, MO.

Read before the Tri-State Medical Society at Chicago, April 4, 1902.

IN speaking to you of plastic surgery in ophthalmology the time allotted will not admit covering the entire subject in detail, so I shall only refer briefly to some of the operations; such as those for distichiasis, trichiasis, entropion, epicanthus, symblepharon and pterygium and dwell more particularly upon these for pronounced ectropion due to partial destruction of the lids and adjacent parts by burns, by lupus, cancer, etc., and to congenital ptosis where there is entire absence of the levator palpebrae superioris. In many persistent cases of trichiasis, distichiasis and entropion where the lashes appear at the mucous line directed toward the eye-ball fretting it and causing keratitis, pannus and kindred troubles, if there is no integument to spare, the operation known as Von Milligan's seems to be the one especially indicated. This consists in grafting a strip of mucous membrane take from the patient's lip or vagina or from the conjunctiva of a rabbit. The operation is made by slitting the margin of the lid at the conjunctival line from punctum to canthus, taking care that all the ciliae are within the outer flap, then into this slit transplant the narrow strip of mucous membrane two or three mm. wide at the center, gradually tapering to a point at each end. The strip is to be held in place at the middle and at both ends by delicate silk sutures passed through the edges of the flaps without piercing the graft, merely overbinding it. This strip wedges the margin of the lids with the erring lashes away from the eye-ball, and so corrects the distortion. But in the majority of cases of entropion, even in triple rows of lashes with many of the ciliae turning against the eye-ball

if the lashes are within the intra-marginal space' I rely upon the cauterization treatment. This operation being to incise with white heat the whole length of the lid from end to end, parallel to and two or three mm. distant from its margin. I use the knife electrode cutting down to the cartilage. In pronounced cases where there is hypertrophied cartilage, I burn slightly into the cartilage, taking care not to go too near the edge of the lid for fear of destroying by the intense heat the hair follicles. The cicatrix caused by the cauterization draws the margin of the lids with the erring lashes away from the eye, correcting the entropion or distichiasis. The cauterization also promotes absorption of the hypertrophied tissues reducing the thickened lid and restoring it to its normal curve. I also use the electro-cautery in the majority of cases of ectropion. In ectropion I make the incision through the palpebral conjunctiva, from near the punctum to the outer canthus parallel to and two or three mm. from the margin of the lid. In aggravated cases I make two or three parallel incisions, the third being at, or near the retro-tarsal fold. Probably 95 per cent of all cases of ectropion which have come under treatment both in my public clinic and private practice within the last three years, I have cured by this treatment. The operations are made under the influence of cocaine and adrenalin, very quickly and without pain or hemorrhage. In entropion I use the cocaine hypodermically, in ectropion by instillation. In symblepharon and pterygium I liberate the band from the cornea or its margin, tuck the band under itself and stitch it there. I then sear the scleral bed with the electro-cautery and close the coloboma with silk sutures. I never clip away any of the tissues. For epicanthus where there is an exuberance of integument, causing a fold over the inner portion of the lids, examplified in Mongolians, I take a diamond-shaped piece of integument from over the base of the nose, then bring the edges together and so lift the fold from the eyelids.

I wish to call attention especially to the operation of skin grafting for the restoration of destroyed lid and to the operation for congenital ptosis. Of course the Thiersch method is not to be considered in cases where the lids are to be restored, and correctly placed; in such cases only plants of the entire thickness of the skin will do. These plants can be used with or without a pedicle. If there is sufficient healthy skin of the adjacent parts, a piece may be slid around from the temple, forehead, nose or cheek with a pedicle; but if the face has been badly burned or eaten by disease, leaving naught but cicatricial skin tissue, then the grafts must be taken, as advised by Dr. Wolf, of Glasgow, from some remote part of the body, preferably, where it is thin and flexible; as from the inner surface of the arm or chest. It has been my experience that grafts without a pedicle are as likely to live as those with, the principal point being to graft them upon a granular surface having them entirely free from blood and subcutaneous connective tissue, and without passing them through any antiseptic fluids. I frequently transplant grafts as large as two by three inches, always cutting them larger than the surface to be covered, so as to allow for shrinkage, which invariably takes place. In building up the lid, for instance, I cut the graft sufficiently large, to shove the margin of the lid upon the eye-ball,

even producing at the time entropion. There is not so much shrinkage of the graft if care be taken to clip away all subcutaneous and areolar tissue before planting it. The following case will illustrate very well this particular form of plastic surgery in ophthalmology. The patient, Mrs. F. W., aged 43, gave the following history: "About two years ago a growth appeared just below the cheek bone of the right side of my face. Our family physician called it ringworm and treated for that, but after two months treatment with no improvement, he changed his mind and began using caustics upon it. At that time a travelling specialist was in the neighborhood and he treated it with a plaster. But in spite of all this, the growth continued to increase. Later on I came to Kansas City and consulted Dr. Knoche who pronounced it lupus and treated it with the X-ray, applied every other day from September 7, 1901, to January 28, 1902, when he pronounced it cured." No history of cancer in the family or any specific disease could be elicited.

As a result of the treatment Mrs. F. W. received from Dr. Knoche the growth seemed to be arrested, but there remained a great deal of cicatricial tissue which contracted the lower lid downward and the corner of the mouth upward, causing a very unsightly appearance, as well as a feeling of constant tension in these parts. The upper eyelid and eye-brow were also involved in the contraction of the cicatricial tissue, resulting from the use of the paste by the "specialist." As a consequence of these contractions, the palpebral conjunctiva of both the upper and lower lids as well as the ocular itself was exposed (Fig. 1), resulting in irritation and inflammation of the cornea, as well as constant epiphora, which excoriated the face.

Five days before making the skin grafts, I made a preliminary operation, by which I liberated the margin of both lids from scar tissue by making incisions from the puncta to the canthus and dissecting the margins till the palpebral aperture could be closed. I then freshened the lids at the mucus line and sewed them together; in other words made tarsorraphy. This left two large raw surfaces, one above and one below the eyelids each of about one and a half inches long and three-fourths of an inch wide which were to give later a succulent granular surface for the skin grafts, securing them thus a better chance to live. The skin for grafting I removed from the chest of the patient, close to the anterior axillary line including both the dermis and epidermis. The dimensions of the surfaces to be covered being each 25 mm. by 47 mm. The pieces removed were somewhat larger to allow for shrinkage. After removal I placed each piece upon the back of my hand and with curved scissors removed any adipose and areolar tissues that were still adherent to the grafts. I then applied the plants, without passing them through any solution, to the granular surfaces of the face, holding them there not by sutures, but by bandage. The grafts were dusted with iodoform powder and dressed with iodoform gauze. This dressing was left undisturbed for one week, and when removed both grafts were adherent throughout, and no evidences of suppuration could be seen. The plants had taken on a pink color, indicating that the circulation of blood had already been established in them.

Both operations were performed under the influence of cocaine, a one per cent solution being used hypodermically. The patient said she felt no pain whatever, and that the unpleasant sensation of drawing at the corner of the mouth was greatly relieved. I do not expect to liberate the margins of the eyelids for two months or more. But shall keep them closed to prevent epiphora which would interfere with the perfect healing of the grafts; and also give a chance for the cornea to recover from the irritation caused by exposure.

Photograph No. 1 represents the condition of the face as photographed by Dr. Knoche during his treatment. Photograph No. 2 was taken ten days subsequent to the planting of the grafts, showing them alive. I have also used skin grafts as a therapeutical agent in smothering out malignant growths of the orbit and of the lids. This treatment I introduced to the profession about twenty years ago in an article published in Dr. Rumbold's Medical Journal of St. Louis.

No. 1.

In conclusion, I wish to call your attention to the operation which up to the present time has given the most satisfactory results in that serious deformity—congenital ptosis—where there is an entire absence of the levator palpebrae superioris. The operation was introduced by Dr. Panas of Paris, he was practising this operation at the time I was with him in the winter of 1888.

The steps of the operation are as follows: First make a deep longitudinal incision through the upper part of the lid nearly an inch long going through all the tissues into the periosteum, the incision curving slightly upward. Then make two curved vertical incisions, starting near the margin of the lid nearly an inch long the inner four or five mm. from the inner canthus and the outer about the same distance from the outer canthus. These incisions only extend through the skin to the tarsal cartilage and approach each other as they reach the upper part to intersect with the horizontal incision, thus making a tongue about four or six mm. wide.

No. 2.

No. 6.

No. 3.

No. 4.

Then another curved longitudinal incision with the curve upward is made about an inch long just at the upper edge of the eyebrow, through the periosteum. The bridge between the two longitudinal incisions is liberated and the tongue of the lid drawn up under this bridge and fastened to the upper edge of the superior longitudinal incision by three silk sutures. If these three sutures cause much ectropion, the latter can be corrected by placing two sutures one at each side through the tarsus and bringing them out and fastening them each at the respective ends of the upper longitudinal incision, as indicated by drawings (Figs. 3 and 4). These sutures should be left six or seven days until the tongue is thoroughly fastened to the integument above. Photograph No. 6 that of the lids ten days subsequent to the operation. This operation was made March 1, 1902, and the photograph (6) was taken March 11, 1902. Sometimes it is advisable in ptosis to perform canthotomy, which is done by incising the orbicularis at the outer canthus; that is, extending the outer canthus thus increasing the palpebral aperture. The incision is made with strong, blunt end straight scissors and extends through the entire orbicularis muscle. Then the mucous membrane on either side and at the fornix is stitched by silk sutures to the integument, to prevent the incision closing. This establishes a permanent extention of the palpebral aperture and assists in correcting the entropion by relieving the constriction of the lid margin.

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A Parsee gentleman of Bombay has given $35,000 to the London School of Tropical Medicine, which is now investigating malaria.

Smallpox, as officially reported in the United States from June 28 to September 19, 1902, amounts to 7168 cases, with 367 deaths. For the corresponding period in 1901, there were 9907 cases, with 282 deaths.

Whether Feeble or Deformed, thin or fat, tall or short, that man has the best chance of reaching three score and ten who eats at regular times and nothing between, whose bodily functions are in regular daily action, and who is kept fully employed in agreeable and profitable activities in the open air. At the same time, the lean have the advantage over the fat, the merry over the morose, the hopeful over the despondent, and the busy over the idle.

Urethritis.—Dr. Chas. E. Woodruff is a strong advocate of the value of hot salt water solutions in the treatment of urethritis. He irrigates every hour, at first, with a quart of salt solution used as hot as can be borne. Of 98 cases thus treated in 5 per cent. all symptoms disappeared in two days; in 30 per cent in seven days; in 30 per cent, in eleven days; in 20 per cent, in seventeen days; in 10 per cent, in twenty days, and 10 per cent were cured in three weeks. After the discharge has stopped, an astringent solution is used for two or three weeks.—*Ex.*

A Few Days with a Country Practitioner.

By W. L. Downing, M. D.

MOULTON, IA.

AFTER an uneventful journey of 150 miles by rail, the train slowed up at the depot where I was met by my friend, whom I had not seen for sixteen years. He was somewhat older than when I knew him as a classmate in medical college, but looking much more of a man. Now, as then, he appeared a perfect type of health for one of his age and build.

A short walk to his residence and I was introduced to his family, consisting of his wife, and their daughter and son, of twelve and seven years respectively. In visiting with the children I was shown the picture of a bright-eyed little girl of eight—their sister—and informed that she had fallen a victim to that dread disease, diabetes, after an illness of six months, a little less than a year before.

A few minutes rest and I was invited into the dining-room, by the way, the most important room in the house, judging by its size and furnishings, where I partook of the many good things prepared by my hostess. Everything was neat, well cooked and inviting. Seemed to me I never did eat with such relish before in my life. In fact I very soon found myself uncomfortably full, to say the least. I ate with what we city physicians choose to call "a coming appetite." I'm not sure that an apology would be in order here for this seeming breach of politeness, because I think most any of you would, perhaps, have acquitted yourselves in like manner, had you the same opportunity, besides I started before breakfast and did not arrive until high noon.

Should you wish to get on the best side of the women—oh, I mean to stand in with them—and I assure you from an experience of several years, that doctor's wives are no exception to the rule—you must not mince around the outside of their tables groaning with good things to eat, but, without ceremony, proceed, as I did to put yourself on the outside of a considerable amount of all the good things at your disposal. Should you fail to do this you might discover, to your own sorrow, that you are soon not quite so welcome as at first thought. To put it in other words, I would have you remember that women, as a class, are *very sensitive* along this line, and should opportunities like these confront you, you must always conduct yourselves accordingly.

Dinner over, I soon found myself behind my friend's laboratory, which was a part of his private office Here was a fine microcsope with triple nose piece, iris diaphragm and abbe condenser, centrifuge, test tubes, chemicals, hemoglobinometer, blood count and all such other apparatus as any up-to-date practitioner might need for such work, and while all was neat and clean, gave evidence of use.

A library, consisting of 150 to 200 volumes, by standard authors, and up-to-date, showed plainly that my friend was his own surgeon, gynecologist, oculist and aurist. On his desk were the American Journal Medical Association, Clinical Review, Chicago; Medical Council, Philadelphia,

and Laryngoscope of St. Louis. Surgical instruments and such other apparatus as were necessary to equip a doctor's office in first-class style, did here and there abound.

A placard, in large letters, announcing office hours, hung conspicuously in the waiting-office, together with another, requesting the public to send all messages early each morning when possible.

The first patient for the afternoon was Mrs. N. "Dock, do you know, I've been as sick as the duece ever since I was here; I vomit the very first thing in the morning—just as soon as I wake up; sometimes its one, sometimes its five o'clock; and when its so early, I just keep it up all forenoon, nearly, the slickest, slimiest, nastiest stuff that you ever tasted, and then I have to spit so much. I don't throw up what I eat much. My husband says I've just got a cold and I'd better take quinine, but quinine makes me lots sicker. I'm *sure*, *he knows better;* he just simply wants me to get my mind off this sickness, that's all. He knows I haven't had my courses for three months, but thinks its because I run out in the cold so much. My husband is so kindy funny anyhow. I don't know whether he's like all the rest of men or not. I told him I'd just like to see him get in this fix once, then I know he'd know better how to sympathize with us poor women." The doctor said, "You ought to take very light food only, of which milk should form the basis; eat lying down, five times daily, remain lying for an hour; get a cool bath with frictions to the spine and limbs after breakfast each morning; take this medicine to keep your bowels open, don't work much; don't think you're going to be sick when you wake up, after eating, and when you get up, but think how you did when you were well, and try your very best to think and act that way and you will come back next time feeling much better."

At 1:40 p. m. a message from the Wabash announced the injury of one of its employes—run over by a loaded hand-car. Six men in a few minutes conveyed the injured to the doctor's office on a stretcher. I was given two hypodermics and asked to get ready for administration of ½ gr. morphia and 1-20 gr. strychnia, which I did, while my friend busied himself in making such other preparations as he deemed necessary. This done, I was asked to put the injured man under chloroform anesthesia, during which time all clothing was removed from head to foot. The doctor hastily but carefully examined all bones and joints, one by one, for possible fractures and dislocations. Upon coming to the left leg, comparison with mate showed considerable shortening; there was also inversion of the toe, together with considerable flattening of the hip at great trochanter. I was now asked to cease the chloroform and steady the pelvis by placing a hand on each anterior superior spine of the ileum, while my friend, after calling my attention to what we had heard Dr. Green say so many times relative to reduction of dislocations: "Put the bones as nearly as possible into the position they occupied at the moment of escape, keep up your extension, rotate the limb in the proper direction and drop it back gently into position." My friend lifted the limb, carried it heavily across its fellow, and gently rotating it outward, it readily dropped into position with an audible snap, heard all over the room. Now it easily lay alongside its fellow, like it in all respects.

At 4 p. m. the telephone rang out a hurried call six miles northwest —a confinement—with fluids already draining away. In a very few minutes we were on our way, as though shot from a small cannon. The doctor said, "I bought these horses over in Missouri last fall. They are western bred, half hambletonian, half brothers, sixteen hands high, weigh in same notch—1080 lbs., deep bays, as you see, closely coupled, white faces, white stocking leg behind, and are seven years old this spring. They were never hitched until a year ago, and virtually unbroken when I got them. They are a bundle of nerves, never fail me, have plenty of the staying quality; all you need to do is to keep your seat, hold on to your strings, and, like the Irishman who made the trip to New York by telephone, 'You'll soon be there,'" and we were in thirty-five minutes.

Immediately upon our arrival, we hastily proceeded to make our hands as aseptic as possible by means of three changes of soap and sterile hot water with bi-chloride of mercury, using the brush very freely. Upon examination found fully dilated membranes ruptured, head presenting in occipits-past position, but closely wedged under symphysis pubis and with history of pains bearing down heavily for an hour. Auscultation and palpation revealed the presence of a second baby. Here was a mother, twenty-four years of age, closely built, weighing less than 100 pounds, a multipara. The doctor having informed husband and wife of the conditions existing, remarked to me that "perhaps we should watch the progress for an hour more and should there be no advance of the head, which is very likely, we'll give her chloroform, apply the forceps and bring the head through the bony part, then allow nature to proceed naturally," which we did. Cord tied and baby removed; further examination revealed the second baby in separate amniotic sac, but with breech presentation which was easily converted into a head. A short lull and the new membranes were ruptured with first pain, and head now engaged in right accipity anterior position. Only a few pains were required to effect delivery. The moment the head came down and began to distend external soft parts, I was asked to make heavy pressure over the fundus and follow it down closely until placenta was delivered and uterus firmly contracted. The uterus failing to contract well, a hypodermic of ergotine together with 1-20 gr. strychnia was administered at once. The husband was instructed to scrub his hands well in soap and sterile water with 1 to 1000 bi-chloride night and morning and immediately after, sponge the wife well with similar solution from umbilicus to feet using all the soap needed; to use only sterile gauze as pads to catch the flow; to give her light food, such as one should take when lying in bed, also a good dose of epsom salts the second morning to unload the bowels, and every second or third morning thereafter, as needed; to put the babes to her breast every two hours during the day, if awake, and two or three times at night, and to give them plenty of water to drink and not feed them under any circumstances. The wife was to remain in bed, quiet, for two full weeks at least, and longer unless she felt that she was doing first-class, and now with further understanding that should *anything* happen or not seem right, it must be reported at once, we took our leave.

We were soon home again. Supper over, I was given a daily paper for half an hour, then the A. M. Journal, until I had scanned its pages somewhat carefully for the best that it contained, the remainder of the evening, before retiring, was spent in talking over our palmy days, the days when we were school boys in the same rural district; of how we boys, twenty to thirty in number, used to gather at his house Sundays, when his father was away preaching, and we would often spend the whole days without our dinners, lassoing and breaking the mules to ride; of how when away at literary college, a number of we boys planned to visit old Mr. Growl-about-everything's peach orchard one night after his bedtime. This particular orchard was about three hundred yards from the house and the old man had kept close watch upon it for some time. Peaches were getting somewhat scarce now, and all that remained were over in the middle of the orchard, and high up in the trees so that it was necessary to climb for them—the nicest and most delicious, saved especially for eating purposes. According to plans, my friend being tall and somewhat fleet on foot, was detailed to enter the orchard and make the search, while the rest of us were to keep watch. After a while he came upon one tree which seemed to be very full, as best he could see in the glare of the moonlight, but all were out of easy reach, and, in his effort to get them, he discovered that the body of the tree supporting them was somewhat frail, so he bends the top well down and carefully twists it off and presently came waddling out with the whole top, which easily proved to have a peck or more of the finest peaches you most ever ate. You know how it is, gentlemen, somehow or other the flavor is much more delicate and the fruit more delicious if it has been purchased when the old man wasn't in. Of how, when in Old Rush we boys used to play high-five or seven-up for all that remained of a "stiff;" of how some of us, upon discovering that our stiff had several teeth filled with gold, carefully dissected it all out, took it down to the city pawn-shop and realizing an easy handsome sum, blew the hole "bizness" in at first opportunity on our way home. Needless to say we didn't get home that Xmas to spend the holiday, but we did spend them in the city calaboose.

At 3 a. m. I was aroused by my friend who said he had just been called seven miles west in consultation; a woman eight months pregnant was flooding to death. Get into your clothes while I get everything ready and we'll be off.

We were soon on our way, and in an hour drove up to Mr. S.'s residence—met by a messenger who said our patient was momentarily expected to die. A glance revealed the fact that a most terrific hemorrhage had occurred—pale, pulseless, cool, clammy skin, with etxremities cold to the body, sighing respiration, etc. The head was at once lowered and foot of bed elevated. I was asked to administer 1-20 gr. strychnia together with $\frac{1}{2}$ gr. morphia with atropiac 1-150 gr. There being plenty of hot water, my friend set to work by hypodermoclysis to fill the vascular system with deci-normal salt solution. As much as two to four ounces were injected in each place until a quart to one-half gallon was administered in this manner.

Soon flushing of the skin revealed capillary dilatation, and it was simply marvelous to see how quickly the vascular system drank up the salt solution and fully as marvelous to observe the ready response of the heart and vessels generally—no pulse at the wrist as compared with one of 160 in thirty, and 120 in sixty minutes.

While the attending physician was awaiting our arrival, he carefully packed the vagina very full of iodoform gauze to restrain further hemorrhage; this it did quite well as hasty examination revealed dilation of os to size of pint tin cup with complete central implantation of the placenta. There now being no hemorrhage, the pains continuing, and patient rallying, it was decided to repack the vagina and await further dilatation. Abdominal palpation revealed R. O. A. position. We waited until dilatation was perhaps two-thirds complete, when the patient's hips were brought to the edge of the bed, upon a Kelly pad, the parts rendered as aseptic as possible, by use of green soap and hot water with 1 to 1000 bichloride, followed by alcohol, when my friend introduced his right hand into the vagina and with sawing motion of the fingers separated enough of the placenta from its attachment to the walls of uterus to admit of entrance of hand and arm into uterus cavity, whereupon he seized both feet and brought them well down, thus substituting foot for head presentation. The membranes were now ruptured, and by traction upon the feet, the child was brought well down until the opening made was packed tightly and all bleeding restrained. Strong traction was made during each pain and child delivered soon as possible, but still-born. The hand was then reintroduced, placenta detached, uterus irrigated with very hot saline solution and with heavy pressure after manner of Crede over fundus, the hand and placenta were soon expelled and uterus remained firm.

The necessary toilet to the parts and the changing of patient's bed and clothing having been attended to, the nurse was asked to adminsiter per rectum, one pint salt solution every eight hours, hoping to have it retained and absorbed; to give an abundance of fluids by the mouth, and only well skimmed milk as nourishment; to have foot of bed elevated until pulse dropped below 100. This done we made our departure rejoicing.

Scarcely had we gotten home, when a message came to again hurry into the country, this time sixteen miles. Cary B., a young man of 18, after slight malaise had a run of fever for two or three weeks, was much better for a few days and suddenly developed pain of cramping nature in region of right hip with disposition to lie toward right side, with right leg drawn up; abdominal walls fixed, slight nausea and vomiting; temperature which had been running low for a few days now jumped up somewhat, 100 to 101½, for five or six days; all above symptoms continuing, but somewhat intensified. There now began to show some fullness in neighborhood of cecum, extending up along outer border of ascending colon, which at this time fluctuated slightly; there was also some enlargement of spleen, together with ochre yellow stools of loose nature.

That this young man had enteric fever all this time, there was not much room for doubt, but what this sudden rise of temperature and this

new groups of abdominal symptoms, just as he was about entering upon convalescence? Did they mean perforation of a Peyer's patch, due to ulceration, with resulting abscess, or were they due to appendicitis with perforation? We were inclined to hold to the latter opinion and acting upon this, the family were asked to get ready the following: To open up their dining-room, which was upon the south, large and airy with floors barren; to dust ceiling, walls and woodwork thoroughly and immediately, follow this with thorough scrubbing with 1 to 1000 bichloride, to air dry it and warm up to 80 degrees; to boil four gallons of water for an hour, turn at once into sterile stone jars, covered with nice clean sterile sheets well tied on and set out to cool; to have four gallons boiling; to get ready the necessary basins, towels, sheets, blankets, hot bricks, table, etc., and we would proceed to operate soon after dinner. The nurse was asked to give the patient a very thorough hot water and castile soap bath at once, to follow it immediately with 1 to 1000 bichloride. A large pad of sterile gauze was applied so as to cover entire seat of operation.

At 2 p. m. patient was anesthetized, seat of operation scrubbed well with green soap and 1 to 1000 bichloride, followed by alcohol. An oblique incision, three inches long was made directly over the most bulging part of the mass and immediately upon entering the cavity, pus of a strong fecal odor, to the amount of one to two pints welled out several inches. The cavity was now poured full of H_2 O_2, and after all bubbling had ceased was washed out well with Thiersch's solution.

Digital examination revealed the presence of a swollen perforated, gangrenous sloughing appendix with post-cecal abscess, this confirming our opinion. Entire cavity was now loosely packed with narrow strips of iodoform gauze, and over this large pad of sterile gauze and absorbent cotton, held in place by strips of adhesive plaster. Patient was not placed in bed, and sustaining no particular shock was left in care of the attending physician. On our way home, in answer to a query as to the probable outlook for the patient, the doctor said, "He'll undoubtedly lose all of his appendix and make a perfect recovery in from four to six weeks," and I have since learned that he did.

Upon our return home, was late at night, being very tired, we went to bed at once.

At 4 next morning, I was aroused by my friend, and asked to accompany him to a house on the edge of town to see an eight-year-old with a bad sore throat. The patient had complained only twenty-four hours. Before a good light we observed both tonsils swollen and projecting well into the median line; little cheesy masses lying about orifices of all their follicles, but easily brushed off; mucous membrane circumscribed; outside at angles of the jaws were quite a group of enlarged, tender lymphatic glands, well cemented together by inflammation of periglandular tissue, forming a mass the size of an English walnut to a hen's egg, temperature 100, pulse 120.

After a few moments consultation, the doctor said, "If we don't get membrane upon these tonsils in twenty-four hours, I shall be greatly surprised. You wait here, see that some boiling water is gotten ready, and

I'll return to the office get some antitoxin, and we'll give her 3000 units of XX."

He soon returned, and this amount was administered. He also brought an envelope which he said he obtained in Chicago a few months ago. "You see it contains this small tin box of blood serum mixture, this wooden spatula and wooden swab of cotton, enclosed in glass tube, open at both ends, but sealed up by these rubbers, which you know are mostly used upon medicine droppers, and this blank card for diagnosis culture, in suspected diphtheria." Before leaving, he removed the swab, rubbed it over both tonsils in such manner as to obtain all cheesy matter possible and with wooden spatula spread it over the surface of blood serum mixture as evenly as he could. Both swab and spatula were now burned. He closed box, sealed with small band of rubber, returned it to envelope and dropped it into his inside vest pocket, remarking that "Diphtheritic bacilli thrive best at body heat." At bed-time the envelope with its enclosed box was transferred to pocket of his night shirt, and thus it was cared for for twenty-four hours. It was now opened. We beheld a growth consisting of small round grayish white granular colonies. A slide and a cover-glass were prepared—upon cover-glass a drop of sterile water was placed, which was inoculated from the growth, spread out as thinly as possible, air dried and fixed by passing three times through an alcohol flame. It was now stained for five minutes with Loeffler's alkaline methylene blue, rinsed in water dried, mounted in Canada balsam and viewed under microcsope, thus confirming our diagnosis, and this almost by the time any membrane was present.

Further treatment consisted of administration of 2000 units of XX antitoxin every twelve hours, until temperature subsided and membrane ragged all over and dropping off rapidly, together with throat wash consisting of sat. sal. acid boric with H_2O_2 in proportion of 1 to 8 used every hour, with no water soon after; quick loose bowels and light diet. In six days all evidence of membrane had disappeared, and in nine days, bacteriological examination showing absence of bacilli, the patient was again allowed to mingle with the family.

And thus I might continue to enumerate case after case which I was permitted to see suffering with the various ailments that man is heir to, this of the eye, ear, throat, nose and chest, that of the abdominal, the other of the genito-urinary organs; all of interest—but I have chosen rather to speak only of those few which were of greatest interest to me.

If I have succeeded in presenting them in such a manner as will enable you to gather a few crumbs at least, then I shall feel repaid for the time and effort spent in their preparation. I thank you.

War Upon the Plague in Odessa.—To check the propagation of the plague through rats, the municipal authorities of Odessa have made the extermination of those animals obligatory to all householders. To further this end, the Bacteriological Institute of Odessa offer, for 60 kopecks (2 francs), half a liter of a culture of rat-septicemia, sufficient to impregnate a kilogram of bread; this is to be given gratuitously to the poor, upon a physician's order.

Conglomerate Cystic Kidney—Report of a Case.

By J. F. Herrick, M. D.

OTTUMWA, IA.

Read by title before the Tri-State Medical Society, at Chicago, April 3, 1902.

THIS case seemed worth reporting because conglomerate cysts of the kidney are not very common, or at least are not often diagnosed. It may aid some one in detecting a like condition.

The patient, B. F., male; single; age 45; clergyman; native of Ireland, of good habits, had always been strong and healthy until the present illness, except for an injury, the result of a fall from a moving street car. The accident occurred in the spring of 1899. He was thrown to the pavement and rendered unconscious as a result of the fall. On being taken home he soon regained consciousness and complained some of his head and back, but especially of one knee, which was badly bruised. He was confined to the house for two or three weeks, principally on account of the knee. The recovery seemed to be complete. Eighteen months later, in the fall of 1900, he lost some weight, and complained of biliousness on a few occasions, but continued about his duties as usual. He made no complaint of any farther trouble at any time until I was called to see him January 20, 1901, at 10 p. m. Found him sitting in a chair, his head drooping on his chest, and the body perfectly limp; he was unconscious and was covered with cold perspiration. He had performed his usual duties during the day, but complained of being tired and ate very little. During the evening some visitors came in with whom he conversed until about nine o'clock, when he seemed sleepy, and they departed. He excused himself for not going to the door, saying he didn't feel well. He called for a drink of water, which he took with difficulty, soon falling asleep, as it was thought. On my arrival he was put to bed. Heat was applied to the extremities, which were very cold. The pulse was 80, large, but very soft and compressible. The heart's action was tumultuous. The organ seemed dilated and weak, and was with difficulty keeping up the circulation. The respiration was slightly sterterous. There was puffing of the right cheek and apparent paralysis of the right side of the body. The eyes were fixed, but were covered by the lids. The pupils, of equal size, and slightly dilated were little affected by the light. The face was pale and as stated above, the entire body was covered with a cold perspiration. There was no swelling, puffiness or dropsy of any part. Altogether there was a condition of apparent profound collapse with the addition of unconsciousness, stertor, paralysis of the right side of the face and body, with rigidity of the left. Under the conditions, in the absence of any history of disease, the suddenness of the onset, and to me, somewhat contradictory symptoms, I was at a loss for a diagnosis.

In about five minutes after he was put to bed the left arm and leg began to show some signs of agitation, being moved about restlessly while the right remained quiet. In half an hour the agitation and twitching of the left side was greater, but when spoken to he seemed partially conscious.

He was given 30 grains bromide of soda by the mouth. In a short time he fell into a quiet sleep from which he awaked in an hour much brighter and apparently better in every way. By morning he was bright, and to all appearance in a normal condition, except that when left alone he would doze all the time.

At this time, on examination, the urine was found to be excessive in quantity, about four quarts in twenty-four hours, sp. gr. 1005, neutral in reaction, very pale and containing a trace of albumen; no casts, no pus nor other abnormal constituents; no abnormalities were discovered on physical examination. A probable diagnosis of contracted kidney was made. In three days the patient was out and about town. He was given very little medicine at first, but after the first two weeks he took glycozone after meals to correct any fermentation in the alimentary canal, on the theory that the products of fermentation in the bowels and sub-oxidation in the tissues may be somewhat responsible for sclerosis of the kidneys. The diet was principally milk. All meat, coffee, tea and stimulants were cut off. Under this regimen there was decided improvement in the urine. The quantity was lessened by one-half. Sp. gr. 1010; thirst was lessened and the patient improved generally. On about April 1st he called on a specialist in urinalysis in this city, Chicago, who reported as follows: Quantity excessive, sp. gr. 1010, some epithelial cells, a few hyaline casts, no pus no albumen, no other abnormal constituents. At a later date another physician of this city reported considerable albumen and some pus cells in the urine. He also reported finding a tumor in the reigon of either kidney, which "appear to be enlarged kidneys." He spoke of the left mass being quite nodular; but in his communication to me ventured no diagnosis. This physician later made an effort to secure a skiagraph of the kidney region with the thought that probably stone might have something to do with the condition. There was no success. During the spring and summer the tumors continued to grow and to become more nodular. On the discovery of the tumors I gave up the idea that it was a case of contracted kidney and finally made the diagnosis of conglomerated cysts.

Nothing new appeared in the case, except that there was a slow failure until about two weeks before his death, when he began to fail more rapidly. About one week before death a slight diarrhea set in. I knew nothing of it for a few days, until Friday, August 16, 1901. At that time he complained of a mild diarrhea, weakness and sleeplessness. Some mild astringent checked the diarrhea, and a few hours sleep was secured that night, Saturday, August 17, he complained only of weakness. Sunday he only partially fulfilled his usual duties. That evening he began to be more or less stupid. Monday he slept all the time, but could be aroused. Tuesday afternoon, August 20, the stupor became profound. He died that night at 2 a. m., just seven months from the first attack.

A very limited autopsy was permitted. Nothing abnormal was found except in connection with the kidneys. The supra-renal glands were about twice the normal size. Both kidneys were a mass of cysts. The cysts ranged in size from a millet seed to a crow's egg. I judge the kidneys would weigh about four pounds each. The right was more prominent anteriorly than the left, but not so broad latterly.

No normal substance could be seen, just a mass of cysts packed together, like a dense bunch of grapes. The pelvis of each kidney was dilated so as to grasp the enlarged kidney. Not being permitted to remove any of the substance, I can say nothing as to the minute anatomy of the mass.

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Degree for Dr. Lorenz.—On November 28 Northwestern University conferred the degree of LL.D. on Dr. Adolf Lorenz of Vienna.

Grave-Robbing Charged.—Indictments have been returned in the courts of Indiana against several physicians and others for grave-robbing. Four physicians of prominence have been arrested, and each one of the four represents a college of differing schools. The arrest of the four physicians, having college connections makes a list of twenty-four who are now under bonds, or in jail, charged with grave-robbing, and complicity in the same.

White Slave Traffic.—According to late reports the city detectives and police of Philadelphia, aided by various charitable and philanthropic organizations of the city, have uncovered one of the foulest abominations of any age or time. It appears agents, backed by a syndicate, have made it a business to visit Continental Europe, particularly Germany, Austria and Russia, and there by misrepresentation induce ignorant young girls and women to go to the United States. The main inducement was that they could readily secure lucrative employment. The victims were brought to Philadelphia and there sold at so much per head to the owners of brothels and held practically as slaves in a life of shame. Many of the victims, ignorant of our laws and customs, believed themselves the chattels in fee of those who held them. A raid by the city police secured more than 100 of these unfortunates, and at least some of the men engaged in this nefarious traffic are under arrest. Every effort will be made to secure for these men and their abettors long sentences in the penitentiary.—*American Medicine.*

Cholera Spreads in Holy Land—The source of the wide-spread epidemic of cholera throughout Palestine, which we have mentioned, was the exodus of panic-stricken fugitives from Egypt endeavoring to escape from the visitation of cholera, which recently swept the valley of the Nile down to Cairo. The crowds escaped through the desert practically by the same route taken by the children of Israel in the exodus under Moses. They reached the Holy Land about October 10, and have spread the disease throughout the country. The lethargic government has been wholly unable to cope with the situation or to restrain the people. The ancient city of Gaza, memorable from the exploits of Samson, suffered severely, 984 deaths being recorded. The epidemic is now decreasing in all the localities first attacked, but fresh cases appear daily in new places. The total number of deaths is stated as 1864. The government is endeavoring to confine the epidemic to Palestine.—*J. A. M. A.*

Department of Clinical Therapeutics

DEVOTED TO CLINICAL EXPERIENCE.

The Value of Reconstructive Therapy in Modern Medicine.

By C. H. Powell, A. M., M. D.

ST. LOUIS, MO.

WE are frequently confronted with what is best to be done for a very large class of run down patients who are either just convalescing from some acute disease, and have called upon their normal physiological reserve to such an extent that waste is daily exceeding repair, or by those who are the subjects of a chronic disease that day by day is sapping vitality, and not only keeping the patient in a condition of invalidism, but rendering them absolutely unfit for the performance of their daily work. In handling these unfortunates we are often sadly disappointed in the results obtained by many of the tonics in general use. From week to week we have our patients weighed, and instead of noting a gain we are disappointed to find the loss of one or two pounds. In the successful treatment of one who is steadily losing weight it is at first necessary to inquire carefully and systematically into the cause or causes that are operating unfavorably, and with a clear comprehension of these facts remedial measures become much easier. In pursuing our investigations there are a vast number of points to weigh; these have reference to in the first place a careful inquiry into the anamnesis of the patient, that in his personal history. We should carefully push our investigations into every nook and corner; get his family history; get his occupation; get his daily habits; get his regularity as to taking food; get his quality and quantitiy of food; ascertain his mode of dress as to a sufficiency or insufficiency, or finally a superabundance of clothing; inquiries into his surroundings as to the presence or absence of conditions prejudicial to a state of health, this includes a knowledge of his living apartments, of his bed as to cleanliness or the contrary, as to the amount of cover he is provided with during sleep, and above all as to the proximity of obnoxious emanations from sewers, bathrooms, excreta, etc. Reconstructive remedies cannot be expected to accomplish miracles when the patient is continually living under surrounding obstacles to his proper normal state of health, whether that be in one of the varied directions outlined in my previous remarks. In the application of our therapeutical remedies we must eliminate every possible obstacle to success by a careful search for whatever is known to our intelligent experience that will militate against results. Right here is where physicians meet with the greatest difficulty in handling patients, particularly is this true with the poor in dispensary practice, where every possible obstacle to success is to be met with. To no class of subjects does this apply

more than the many tuberculous cases that come before the dispensarian. This disease our experience is daily teaching us is curable in a large proportion of cases, but to bring about a cure important adjuvants to therapy must be adapted, such as the ingestion of proper food, the guarding against atmospheric changes by wearing suitable clothing, the living in quarters that are properly warmed, properly ventilated, etc. Given then two subjects with tuberculosis of the lungs, one so situated in life that every principle desired in the successful treatment of the disease can be carried out, and the other deprived of many of these vital requirements is it a wonder that we are so often disappointed in obtaining the results from our remedies desired. To illustrate my meaning, suppose we are consulted by one of this poor class referred to, and the indications tell us that the appetite must be restored by the administration of a tonic, accordingly we prescribe such an efficient tonic as our knowledge indicates is useful under the circumstances. From time to time the patient returns to us, and we note a falling off in place of a gain; under these conditions if we will take the trouble to inquire a little more minutely into the causes we will often learn that the patient has a strong appetite, but the cause of our failure to bring about the condition aimed at with our tonic is due to the palpable fact that our patient is really unable financially to obtain the food necessary for the accomplishment of our purpose. My practice brings me in contact with many of these cases, and my success in handling run down subjects is largely due to my plan of campaign, and especially is this true with the class who are placed often through no fault of their own in precarious financial circumstances. In the use of an agent the principle to be aimed at and obtained, must be some remedy that will possess these properties: First.—It must be a tonic. Secondly.—It must be a reconstructive, that is, possess the properties of adding to the body the elements required. Thirdly.—It must be well tolerated by the stomach and digestive organs generally, for any remedy that will fail in this last requisite will most surely fail in its application. The hypophosphites have long assumed the leading role to meet these requirements, but whereas, the anorexia is often benefited, the hypophosphites have no efficacy to add substance in the shape of fat to the body. Cod liver oil has always claimed pre-eminence in the treatment of this class of subjects, but cod liver oil has possessed qualities that rendered its use in many cases so extremely objectionable as to absolutely preclude its use, these objections were in the shape of its oily, fishy taste, which for hours after the use of the oil could be tasted by the patient, and finally the remedy was obliged to be laid aside for something more in accord with the requirements. Now this fact of the value of cod liver oil in the treatment of run down subjects has nevertheless never for a moment escaped the intelligence of the medical profession, but to obtain such a preparation of the oil as would meet the requirements was a great difficulty.

A preparation which fills this need is Hagee's cordial of cod liver oil with hypophosphites, prepared by the Katharmon Chemical Company. An extended experience, covering all of fifteen years, with this cordial has been so uniformally satisfactory as to lead me to consider it the most effective, least objectionable and most generally useful form in which cod liver

oil can be administered. The following are a few from among the many cases I have recorded where Hagee's cordial has demonstrated its value as a reconstructive agent, the report is necessarily abbreviated, but must be of interest and value.

Case I.—During the month of July I was called to see a Mr. McL. who had a well developed case of typhoid fever. The disease was unusually severe, and came very near sapping the patient's life. Parenchymatous changes showed themselves very pronouncedly in his heart muscle, and after the fever had subsided the pulse continued persistently above 100 per minute. In order to tone up his system, and add strength to his heart muscles I gave him Hagee's cordial of cod liver oil three times daily in tablespoonful doses. In three weeks' time he has been restored to a perfectly normal state, his pulse taken a day or two ago was 80 beats per minute, and he felt well.

Case II.—May 13th, 1902, Susie C. was brought to me by her mother for a distressed sensation in her epigastrium, difficulty in breathing, and general malaise with anorexia. I learned upon questioning that her age was 12, and that she had passed some blood per vagina. Diagnosis of chlorosis made, and patient given five drop doses of tincture chloride of iron one hour before meals. After keeping her on this plan of treatment for several days the mother stated the child did not eat anything, and she could not observe any special change for the better. Acordingly continued the iron, but added to my treatment a half tablespoonful of Hagee's cordial of cod liver oil after each meal. In two weeks time my patient was sufficiently well to need no further remedies.

Case III.—During the summer just passed John D., of Lincoln county, Mo., was sent to me by his physician who believed consumption had attacked the man's lungs. A careful examination showed the lungs in a normal state, but the history of malaria, together with the coated tongue, enlarged liver, and slight elevation of temperature pointed to a malarial causation. Blood examination showed the plasmodium malariae. Treatment by quinine, iron and strychnine, together with Hagee's cordial of cod liver oil after each meal in two tablespoonful doses was followed with a quick and complete recovery. The efficacy of the Hagee's cordial must receive due consideration in the sbusequent cure of this case, as his previous physician had given him the quinine, iron and strychnine treatment prior to sending him to me.

In conclusion, I will say that it is just in this very class of cases that the use of cod liver oil is to be found the most reliable in restoring the patient to his proper state of health. There are many cases where cod liver oil is indicated aside from tuberculous subjects, and Hagee's cordial of cod liver oil with hypophosphites meeting every demand that can be made upon it has no equal to enable the physician to obtain the mastery in a short time over disease. It is furthermore to be especially recommended in so far as it is not influenced by climatic changes, it is just as pure, just as agreeable to the taste, and just as efficient in midsummer, with the temperature at 100 degrees, as it is where we are having zero weather, the same cannot be said of the other cod liver oil preparations.

Society Proceedings.

MISSISSIPPI VALLEY MEDICAL ASSOCIATION.

Proceedings of the Twenty-Eighth Annual Meeting, Held at Kansas City, Mo., October 15, 16 and 17, 1902.

STENOGRAPHICALLY REPORTED FOR THE MEDICAL FORTNIGHTLY.

[CONTINUED FROM PAGE 806.]

CROUPOUS PNEUMONIA.

Dr. Wm. T. English, of Pittsburg, Pa.,discussed some of the signs and symptoms of this affection. He also dwelt at length upon the easiest and best methods of speedily and certainly determining them. He mentioned the application of remedies suitable to the case and stage of the malady; the advantage of grouping some phenomena in securing a speedy diagnosis, and the necessity for observing all signs and symptoms in differentiating diseases with similar manifestations.

PNEUMONIA.

Dr. Wm. F. Barclay, of Pittsburg, Pa., contributed a paper on this subject. He considered the clinical history of pneumonitis; the close relationship between pneumonia and la grippe; the similarity in pathology, initial stages, clinical history, mortality, and treatment.

The exciting causes of pneumonia and la grippe were identical. The history, duration and progress of these diseases differed but little. The two diseases frequently co-existed in the same individual. The affections differed in the structures of the organ affected.

He believed a rational treatment was based on a study of the immediate causes of death in pneumonia,as concluded in a large number of death reports in the city of Pittsburg. Heart failure and exhaustion stood out as the immediate cause of death in 98 per cent of all reported deaths in a circumscribed area of almost one million people. Rest in bed in well ventilated rooms, apart from atmospheric conditions, was of paramount importance. He had learned from experience that a most decided course of medication was indicated in the treatment of pneumonia, and that a like course of treatment in cases of la grippe robbed the disease of its terrors. First, rest in bed with requisite protection from atmospheric influences; second, a thorough cathartic of calomel was essential in bringing about a decisive derivative action of the secretions of the body. Five to ten grains of calomel, thirty to sixty grains of milk sugar was a formula that had never disappointed him in its beneficial effect. The action of nux vomica, when properly administered, never failed in its power to alleviate the symptoms and afford relief. Tincture of nux vomica should be given in large and frequent doses, well diluted in water.

TREATMENT OF CHRONIC DYSENTERY.

This paper was read by Dr. John L. Jelks, of Memphis, Tenn. The disease was considered of microbic origin, although a specific organism had

not received general acceptance as the sole casual factor. This was the basis of all treatment. No matter what the classification of the disease, the same general idea as to treatment must obtain, namely, the destruction of the micro-organism, drainage, cleanliness, rest and restoration of the tissues. An erroneous idea had prevailed that the disease was beyond the reach of any possible topical medication, further than perhaps the use of the Wales metal bougie, which was not always a safe procedure. The sigmoidoscope and long rubber tube had a field in the treatment of this affection, and it was necessary to educate the profession as to the possibilities of this method. The patients should be placed in sanitary surroundings free from unnecessary heat and moisture. The diet should be carefully selected. The stomach should receive careful attention. The portal engorgement should be relieved and the intestinal tract thoroughly cleansed. Hemorrhage from the bowel when profuse could be controlled by styptic enemata given through the double tube. In using the sigmoidoscope, the author recommended the knee chest position. The bowel should be thoroughly cleansed through this instrument with antiseptic washes applied very hot. If there was much excoriation or ulceration, nitrate of silver might be applied to bleeding and eroded surfaces with a cotton probang, or in the form of a spray. Higher treatment may be administered through one or two tubes of soft rubber, which can be passed further into the colon and the antiseptic solution administered by enema through these. If necessary, boracic acid, iodoform, or aristol may be insufflated through the sigmoidoscope and the bowel thus thoroughly covered.

In the chronic state he had found most benefit from iodoform and ichthyol made into suppositories and passed through the sigmoidoscope into the sigmoid. This was especially indicated in tubercular conditions, but had its use in any form of procto-sigmoiditis or colitis. All toxic drugs must be used with caution.

SURGICAL SECTION.

CANCER OF THE RECTUM.

Dr. Emerson M. Sutton, of Peoria, Ill., read a paper on this subject. He reported cases of cancer of the posterior vaginal wall penetrating to the submucosa of the rectum, with fibrous, but non-malignant, infiltration around the rectum producing stricture. He operated by the sacral route, resorting to the von Volkmann-Rose incision. He resected the vagina, rectum, and one-half of the cervix, anchoring the healthy end of the sigmoid to the gluteal incision side of the wound. He mentioned other cases from the literature, and then gave reasons for attempting operations for extensive cancerous growths situated in the pelvis.

TREATMENT OF EXTENSIVE RECTAL STRICTURES.

Dr. Emil Ries, of Chicago, pointed out the difficulties in treating these strictures. He referred to septic conditions, anatomical changes, and the danger of recurrence. He discussed anastomosis after resection; end to end anastomosis; anastomosis without resection; side to side anastomosis

after exclusion, and end to side anastomosis. He detailed his first case operated upon by the latter method, saying that the patient was well over five years after operation.

URETERAL CATHETERISM; ITS VALUE IN MALE AND FEMALE.

Dr. Bransford Lewis, of St. Louis, Mo., said the purposes of ureteral catheterism in connection with the cystoscope were for diagnosis and for treatment. Cases reported showed that ureteral catheterism, in both male and female, had been reduced to a practical procedure. With the author's cystoscope, the operator was enabled to look directly on the field. Air was used for inflating the bladder. One or both ureters may be catheterized at the same sitting. The operation was performed under local anesthesia.

Case I showed the falsity of an X-ray diagnosis of stone in the ureter. Case II showed chronic unilateral pyelitis and cystitis. Irrigations of the pelvis resulted in a cure. Case III was one of tubercular inflammation of the bladder and kidneys, which improved under irrigations. Case IV, hemorrhagic cystitis and bilateral pyelonephritis; under irrigations of renal pelvis was much improved.

Dr. Eastman, of Indianapolis, thought a removable roof to facilitate withdrawal of the cystoscope, leaving the catheter in the ureter, would be an improvement.

Dr. Martin, of Missouri, found the introduction of the catheter easier than it would seem, and there was no trouble in withdrawing the cystoscope while the catheter was in the ureter.

THE MECHANICS OF INTUBATION.

Dr. C. F. Gillmor, of Creston, Iowa, discussed the mechanical problem of intubation, and exhibited drawings and X-ray plates. He emphasized the importance of acquiring manual familiarity with instruments; the means by which this may be acquired, and then alluded to the problems of intubation and the difficulties of extubations.

LAMINECTOMY FOR FRACTURE DISLOCATION OF THE FOURTH AND FIFTH CERVICAL VERTEBRAE.

In the case reported, the author, Dr. Joseph Rilus Eastman, of Indianapolis, Ind., stated that laminectomy was followed by improvement of motor and sensory conditions, but was unsuccessful so far as saving the life of the patient was concerned. Death occurred on the nineteenth day.

After going at length in the literature of the subject the author said that laminectomy for fracture or dislocation should be made early. The longer pressure had existed, the more extensive degeneration of the cord. Still hope may not be entirely abandoned in old cases, for laminectomy had relieved many such even after months had elapsed since the injury was received. Laminectomy *per se* was not dangerous. It represented the surest method of diagnosis of fracture-dislocation, and the most rational and efficient means of relief.

Dr. Stewart, of Chicago, agreed with the essayist in advocating early operation.

Dr. Black, of Jacksonville, Ill., advised early operation or exploratory incision. Two hundred and fifty cases operated on, out of a total of 555 cases in the literature, showed 25 per cent. better results than the unreported cases

EXTRINSIC TRAUMATISMS OF THE SPINE; THEIR DIAGNOSIS, PATHOLOGY AND TREATMENT.

Dr. Thomas Manley, of New York, read a paper with this title. In the present study of all lesions of a traumatic character sustained by the rachidian structures or the medulla spinal is not followed by clinical manifestations of central complication will be included under the term extrinsic. These were designated (1) contusions; (2) sprains; (3) hemorrhage; (4) fractures; (5) diastasis and luxation; (6) structural and visceral complications.

The most frequent injuries, according to the author were external to the spinal cord. They were rarely of such a character as to seriously impair function, although deformity and impairment of strength occasionally followed. No serious effort had yet been made by an American author to classify the pathology to elucidate symptoms, or to establish the differential diagnosis in this important group of traumatisms.

SPINAL CONCUSSION.

Dr. Carl E. Black, of Jacksonville, Ill., in a paper on this subject called attention to the loose way in which the term concussion of the spine was used, and to the unclassified condition of such cases. The best dictionaries are quoted to show that the word concussion is misused, and should only apply to the manner in which the injury was received. A great deal of misunderstanding had arisen from the attempt of various authors to use the word to describe a distinct disorder. The various authors on surgery were quoted to show that there was a misunderstanding among writers as to the scope of the term concussion. The work of Wm. Thorburn, of Manchester, Eng., was quoted as being the only rational effort which had been made to classify these disorders.

In conclusion, the author took the position that minute or capillary hemorrhage was the basis of most, if not all, of these cases, and gave the following classification of injuries produced by concussion of the spine: Primary effects (1) sprains; (2) contusion of the spinal cord; (3) minute hemorrhage into or around the cord.

Secondary effects or complications (1) Shock or collapse; (2) acute hysteria; (3) neurasthenia; (4) chronic hysteria.

The essayist concluded with the following sentence: "It is certainly the duty of every surgeon to protect himself as well as any corporation he may represent and the best interests of his patient, by distinguishing, if possible, between the purely psychical, secondary psychical, and the truly pathological condition, and treatment should be directed accordingly."

SPINAL CORD INJURY—SO-CALLED SPINAL CONCUSSION OF THE CORD.

In this paper Dr. Frank Parsons Norbury, of Jacksonville, Ill., stated that a scientific interpretation of concussion of the cord so-called had not

yet been attained. The term had become established by long usage, and was largely used because of the want of a better term to cover the clinical picture which it aimed to present. The lesion was doubtless a disturbance of the circulation due to injury to the blood vessels and lymphatics. Intramedullary hemorrhage was thought by the author to be the immediate lesion. This conclusion was supported by the observations of Kocher, Thorburn and Horsley on the surgical side of the controversy. Neurologists had varied views, some of which were decidedly hypothetic. However, most of them were inclined to the view that structural changes were probable,and that the degenerative and vascular changes, following injury to the cord, were indicated in the symptomatology of the disease. Facts were accumulating which made this view both tenable and reasonable. While many injuries to the cord showed no external evidences, the symptoms which followed indicated structural changes occurring within the substance of the cord, and irritation of the cord roots by meningeal involvement. The symptoms in pronounced cases of hemorrhage were compared to the more obscure conditions called concussion,showing that hemorrhage was common in traumatism of the cord ; that similarity of sensory and vaso-motor changes existed.

The author said regarding the psychical element in cord injuries that it was impossible to eliminate it. It was, therefore, important to recognize the definite and demonstrable symptoms—the symptoms which came on gradually, which in their entirety proclaimed the hemorrhagic origin of the disease.

The neuro-pathology of to-day was leaning towards the organic origin of many diseases heretofore regarded as functional. Concussion of the cord was, in the judgment of the author, one of the most marked of these diseases, and he believed the research work of the future would establish this belief.

Dr. Edwin Walker, of Evansville, Indiana, read a paper on

THE X RAY IN THE TREATMENT OF MALIGNANT GROWTHS.

The X-ray has given favorable results thus far. Its exact status must be determined by clinical observation. He reported a case of alveolar melanotic sarcoma of the face, which was removed. The growth returned in two weeks and had extended to the neck. A secondary operation was performed a month later. There was rapid extension from that time, so that within a few days almost the entire neck was involved. The wound had not healed. There was immediate improvement after the use of the X-ray. The wound had cicatriced in two weeks, and all indurations had disappeared at the eud of three months. The patient at this time seemed entirely cured.

He spoke of the extent ef the effects of the X-ray on pyogenic germs. A test was both in test tubes and Petri plates,the exposure to the ray being from ten to thirtv minutes, The results were negative.

While the X-ray was of undoubted value in malignant growths, it should not be adopted to the exclusion of other known methods. Excision should be done, if possible, before the X-ray treatment was begun.

[TO BE CONTINUED.]

ALTON RAILWAY SURGEONS.

Second Meeting of the Association held in Bloomington, Ill.

The Chicago & Alton surgeons held the first meeting since their organization last spring, in the Arnold Hotel, Thursday, November 13th, and had an attendance of nearly half the membership. There are sixty-five surgeons in the association. Dr. M. W. Rodes, of Mexico, Mo., presided, and Dr. F. H. Page, of St. Louis, was secretary. Two vice-presidents, Dr. W. E. Guthrie, of this city, and Dr. F. A. Howard, of Slater, Mo., were also present. The other surgeons present were: Howard Crutcher, of Chicago, consulting surgeon of the road; M. B. Titterengton, of Jerseyville; C. E. Black, of Jacksonville; C. A. Allen, of Virden; J. P. Denby, of Carlinville; W. M. Picquard, of Kansas City; J. A. Klein, of Joliet; J. J. Pearson, of Pontiac; Joseph McCall, of Fulton; E. H. Higbee, of Roodhouse; Scott, of Venice; B. P. Bradburn, of Pearl; J. D. Whitley, of St. Petersburg, and D. H. Galloway, of Chicago.

The meeting was held in the hotel parlors and three papers were read and discussed. Dr. W. M. Picquard, of Kansas City, read a paper on "Burns and Scalds." (This paper will be printed in full in the next issue of the FORTNIGHTLY.) Dr. Black, of Jacksonville, took up the subject of "Records of Cases," and Dr. Galloway, of Chicago, read a paper on "Anesthesia." In addition to these papers the time was given over to the discussion of railroad cases, the best manner of getting to them and caring for them afterwards, the removal from the scene of accidents or sudden sickness to hospitals or homes, facilities on regular trains for caring for emergency cases, and similar subjects.

Election of officers was held and in consideration of the fact that this was really the first scientific session of the organization, the old officers were all re-elected for the ensuing year.

It was decided to hold the next meeting in Kansas City the second Monday in October. Following the meeting Dr. W. E. Guthrie entertained the visitors at 6 o'clock dinner at his home.

THE WESTERN SURGICAL AND GYNECOLOGICAL ASSOCIATION

The twelfth annual meeting of the Western Surgical and Gynecological Association will be held at St. Joseph, Mo., December 29 and 30, 1902. The banquet will be given at Hotel Metropole, by the St. Joseph Medical Society on Monday evening.

Following are the Officers: President, Jas. E. Moore, Minneapolis, Minn.; first Vice-President J. R. Hollowbush, Rock Island, Ill.; second Vice-President, W. W. Grant, Denver, Colo.; Secretary-Treasurer, Geo. H. Simmons, Chicago, Ill.; Executive Council, A. F. Jonas, chairman, Omaha, Neb.; O. B. Campbell, St. Joseph, Mo.; H. C. Crowell, Kansas City, Mo.; C. H. Mayo, Rochester, Minn.; A. H. Ferguson, Chicago, Ill.; Chairman Committee of Arrangements, C. H. Wallace, St. Joseph, Mo.

PRELIMINARY PROGRAM.

Carcinoma Uteri, H. C. Crowell, Kansas City, Mo.

Inguinal Hernia, A. E. Benjamin, Minneapolis, Minn.

Chemical Asepsis, Lewis Schooler, Des Moines, Iowa.

Evolution of the Treatment of Rectal Cancer, C. H. Mayo, Rochester, Minn.

Sarcoma of Long Bones, A. E. Halstead, Chicago, Ill.

Report of Cases: (a) Rupture of Gall Bladder from Vomiting; (b) Perforation of Appendix; (c) Acute Yellow Atrophy of the Liver, W. W. Grant, Denver, Colo.

Tubercular Peritonitis, J. B. Murphy, Chicago.

Lung Surgery, illustrated by lantern slides, B. Merrill Rickets, Cincinnati.

Operations for Appendicitis during the Acute and the Chronic Stages, Compared and Analyzed from a Pathological and Practical Standpoint, A. C. Bernays, St. Louis.

Surgical Treatment of Tubercular Peritonitis, Wm. Jepson, Sioux City, Iowa.

Surgical Treatment of Tubercular Peritonitis, D. S. Fairchild, Clinton, Iowa.

Primary Intestinal Tuberculosis, L. I. McArthur, Chicago.

Diffuse Septic Peritonitis: Etiology, Pathology, Symptoms, Diagnosis and Treatment, Daniel N. Eisendrath, Chicago, Ill.

Report of Two Cases of Acute Intestinal Obstruction Following Contusion of the Abdominal Walls, J. E. Summers, Jr., Omaha, Neb.

The Surgical Anatomy of the Superior Ganglion of the Sympathetic, H. D. Niles, Salt Lake City, Utah.

Chronic Pancreatitis and Pancreatic Cyst, B. B. Davis, Omaha, Neb.

Cases Illustrating Unusual Occurrences after Abdominal Section: (a) Acute Dilatation of the Stomach following Cholecystotomy; (b) Cesarean Section followed by Gangrenous Perforation of the Posterior Uterine Wall; (c) Iodoform Poisoning Simulating Deferred Shock after Evacuation of a Posterior Appendicular Abscess; (d) Spontaneous Recovery following Exploratory Laparotomy in a Case of Adhesive Tuberculosis of the Peritoneum, G. G. Cottam, Rock Rapids, Iowa.

Hyperplasia of the Uterus, C. G. Geiger, St. Joseph, Mo.

A Case of End-to-End Anastomosis of the Popliteal Artery for Gunshot Surgery, Alex. Hugh Ferguson, Chicago.

The Treatment of Retrodeviations of the Uterus, C. A. Stewart, Duluth, Minn.

Gunshot Wounds of the Stomach with Report of Case, J. W. Anderson, Mankato, Minn.

The Value of the Fowler Position in Abdominal Surgery, Van Buren Knott, Sioux City, Iowa.

President's Address.

DR. MARY NEWELL, who has been for some time associated with Dr. Mary H. McLean of this city, has nearly completed arrangements preparatory to her departure for China where she is to have charge of the medical work in one of the missions.

MEDICAL MEMORANDA.

I had long been looking around for a simple yet effective remedy to relieve cough and have found it at last in terp-heroin (Foster).—Dr. VAN DAACKE, Chicago, Ill.

I have used aletris cordial for menorrhagia and dysmenorrhea, and find it an invaluable remedy as a uterine tonic. The aletris farinosa has for a number of years been a great favorite with me in derangement of the female reproductive organs, therefore I recommend it as a tonic in uterine troubles, as it will give satisfaction to those afflicted with such diseases.—C. A. GOSHEN, M.D., Petalma, Cal.

Going South?—Physicians and their patients who are southward bound can find excellent accommodations and a salubrious climate at Hot Springs, Arkansas, the "Carlsbad" of America. The Park Hotel, under the management of Mr. J. R. Hayes, (late of the "Grand" Mackinac Island) and C. A. Brant, is one the most popular houses in this celebrated resort, and your stay is sure to be a pleasant one if you make this house your headquarters.

Stenosine.—The arsenical (mineral) preparations used in therapeutics hitherto, always have been dangerous and difficult to employ, on account of their toxic properties and intolerance. Organic arsenical preparations, however, seem to be free from these inconveniences and on this account, the cacodylates have been largely used in recent years, although they also have certain defects, such as the fatigue they occasion in the stomach and production of disagreeable garlic-like eructations. In order to obviate these annoyances, M. Armand Gauthier the well known authority on medico-chemical questions, has investigated the physiological properties of the di-sodic methylarsinate. This drug taken internally, does not produce gastritis, dyspepsia nor garlic-like eructations and fetid breath, and is a powerful remedial agent which has a number of useful applications. Di-sodic methylarsinate increases the appetite and strength, while the number of red blood corpuscles are augmented. In tuberculosis, its effects are not less remarkable; the tolerance is perfect, all patients can take it, whereas the cacodylates cannot be retained by some persons. In anemia, weakly, chlorotic, nervous and fever patients, as well as in those suffering from cachexia, diabetes, etc., the respiratory exchanges become normal and more active. All these considerations, joined to the non-toxic property of this arsenical salt, tend to prove that stenosine (di-sodic methylar sinate) has a great future before it in the treatment of disease. Indications: Paludal fever, skin diseases, chorea, the vomiting of pregnancy, adenopathy, anemia, leucemia, asthma, grippe, bronchitis, emphysema, tuberculosis, etc. Dose.—Each capsule of stenosine contains one centigramme of di-sodic methylarsinate, incorporated with an inert powder, which favors its assimilation in the organism. One to five capsules daily, to be taken at meals.

"Every Clinician an Historian."—Lord Macaulay briefly epitomized history as the "Record of Events." Be it so. The pleasant task of collection and verification of data falls upon the historian, who retell in an

interesting and enthusiastic manner the lives and acts of others. In medical history, as in secular, the value of an epoch often rests upon the work of the individual, and the true portrayal of one incident in life lends color to the complete narrative. Acts not words illustrate the advance of progress in science and literature. The desire of one person to know precisely why another individual preferred certain methods to old-established forms necessitated history. The narrator of the events of daily life is the true historian and produces items of interest worthy of future history. The construction of records from this material constitutes the validity and worth of the article. What you do and tell today, if approved, your fellow-man will perform tomorrow. Therefore the discovery of an aid to the burden of work-a-day life is more important than determining a new chemic element. One helps the masses; the other invites speculation from the few. History thus recites incident. Incident depicts facts, and facts destroy theories, as the following abstract convincingly states: "We had here a most formidable state of things to deal with: A woman in childbed, with every indication of septicemia—a double pneumonia, probably of septic origin, with constant pain in hip and lumbar region, with persistent vomiting and diarrhea, temp. 105 degrees. A large tympanitic abdomen, small wiry pulse, cyanosis, with finger nails quite purple. Dr. Tibbetts several times informed me that I could look for a fatal termination, so extreme was the case . . . the best thing to do was to curette, which was done, and followed by hot bichloride douches. . . . no abatement in temperature. Morphine had to be given hypodermically to comfort patient, besides strychnine, cactus, brandy and digitalis to support the heart's action. Just here I must say that I administered antistreptococcic serum with very gratifying results. We also used injections of salt solution. I believe the benefit from these injections was more lasting than from those of serum. Antiphlogistine was applied over hip, lumbar nerves and sciatic nerve. This agent (antiphlogistine) was our mainstay in the treatment of both lungs besides. The abdomen became as large as before confinement, hard and resonant on palpation. Antiphlogistine was therefore spread all over the abdomen. I know of no preparation that has been brought to the attention of the profession of late years deserving of higher praise in all inflammatory conditions, no matter in what locality such may be seated. Poultices have been abandoned by the writer since the adoption of its use. Puerperal septicemia complicated by septic double pneumonia. Abscess of thigh.—recovery.—C. C. PARTRIDGE, M. D., in American Surgery and Gynecology, October, 1902.'"

Had it not been for antiphlogistine, what would have been the result of the case? Again, had it not been for antiphlogistine, what pleasure would the attending physician have taken in making a public record of his case? The inference is marked. Here is a patient *in extremis* with the entire 900 official remedies of the Pharmacopoeia at the disposal of consultant and attendant. Every surgical and medical accessory available, and yet one pharmaceutic preparation proves adequate to the emergency. Demonstrating beyond criticism that antiphlogistine should be applied in every process of inflammation. That antiphlogistine relieves blood pressure tension by induction of osmosis and dialysis.